Personalisation and Self-Care
Case for Change
April 2016
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Executive Summary

Poor citizen experience and outcomes; growing demand from an ageing population; increasing prevalence of people with one or more long term conditions; fragmented and unsustainable models of care and an unprecedented financial challenge are all reasons underpinning why the health and care system needs to empower people and communities to take control and proactively self-serve.

In October 2015 the HLP Personalisation & Participation Programme accepted the challenge of producing the first documented Case for Change, seeking to address the fundamental question:

“do more informed and enabled citizens coupled with more personalised models of service provision really deliver better outcomes, at lower costs and achieve value based commissioning when implemented at scale?”

The Case for Change was presented to the London Transformation Group in December 2015 and the London Regional Executive Team in January 2016 and was positively received at both meetings.

Since the announcement of the national Self-Care programme, the £584m Self-Care efficiency aspiration and the publication of the NHS Planning Guidance, with its commitments to patient activation, self-care and the major expansion of personal health budgets, we have revisited the Case for Change. It is now more accessible to SPG and CCG leaders and to help them with the development of their 5 year place-based Sustainability and Transformation Plans (STPs).

Ultimately, the programme wanted to produce a document that would provide practical assistance to SPGs in STP development before plans are submitted at the end of June 2016.

The Case for Change takes the form of a two-page “Bitesize” version (slides 4-6); a headline summary of the policy context and key findings from the evidence (slides 6-28); and a formal and more comprehensive 82-page literature review of over a hundred sources.

Reassuringly, the evidence base is strong and consistent enough to support the scaling-up, spread and coordination of a number of person and community-centred approaches. We’ve made a start in demonstrating the potential financial impact of a number of interventions. Our analysis on Social Prescribing and Patients Online is set out on slides 22 and 27.

In the slides that follow we present 5 reasons why SPGs should consider investing in personalisation and self-care. These are:

• Investing in personalisation and self-care is the right thing to do;
• We can’t continue as we are;
• Person and community centred approaches work;
• People want Self-Care, would like a more active role and want digital channels; and
• The evidence base needs to evolve.

We also set out six things SPGs need to consider for their STP development which includes an offer of continued support from the Healthy London Partnership. You can contact Shaun Crowe on shaun.crowe@nhs.net for further information and assistance.

We hope you find this document helpful.

Graham Mackenzie
Joint SRO
HLP Personalisation and Participation Programme

Jane Barnacle
Joint SRO
HLP Personalisation and Participation Programme
Bitesize Case for Change
Bitesize Case for Change (Slide 1 of 2): Five Reasons why SPGs need to invest in Personalisation & Self-Care

- **Investing in personalisation and self-care is the right thing to do.** There is a strong moral and ethical case for developing a health and care system which starts with what matters to people, what skills and attributes they have, and recognises the contribution strong communities can make to support health and wellbeing.

- **Person and community centred approaches work.** There is a growing body of evidence showing that a diverse and wide range of activities, interventions and approaches lead to better outcomes and significant benefits for individuals, services and communities. This can be demonstrated through improved mental and physical wellbeing, contributing to NHS sustainability and wider social outcomes.

- **We can’t continue as we are.** Poor citizen experience and outcomes; growing demand from an ageing population; increasing prevalence of long term conditions; fragmented and unsustainable models of care and an unprecedented financial challenge are all reasons underpinning why doing things differently is important.

- **People want Self-Care, would like a more active role and want digital channels.** There is compelling evidence that people want Self-Care, digital access to self-serve and would feel far more confident to actively self-serve if they had guidance and support from a professional or peer.

- **The evidence base needs to evolve.** London can lead the way through a combination of building the research evidence along with implementing, testing and evaluating person and community centred approaches. More evidence is needed on what interventions work in what circumstances, how to embed and scale the most effective approaches to achieve best case ROI and the system levers (workforce, contracting, incentives etc) to enable spread.

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5 reasons why SPGs need to invest in empowering people and communities to take control and proactively self-serve

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“I feel like a different person after I attended the course. I came out feeling very motivated and determined to take control of my health. I saw other women like me in the same situation and that made me feel I wasn’t alone.”
- Bhavana, Diabetes service user

“I was approached by my GP practice and they asked me if I wanted to join this programme. They weren’t pushy and just gave me a mobile number to call if I was interested. I had a think about it and thought ‘why not?’, and I’m so glad I did!”
- Dominic, Mental Health service user

Without Positively UK I wouldn’t have been the person I am today. Through the support groups I was able to make friends and I now have a social life. Through the motivation I received I went back to school, have gained a BA and look forward to getting back to work.
- Positively UK Service user
Select the most effective person and community-centred approaches to achieve the best-case ROI for their local populations.
NHS England has estimated that £584m efficiency savings can be achieved nationally through Self-Care by March 2021. The evidence tells us that there is a wide-range of interventions to choose from. We’ve narrowed this down to 11 approaches which can be grouped into the 3 themes of self-management support, community-based and enabling approaches.

Develop a clear plan for widening access to personal health budgets to new population cohorts beyond NHS Continuing Healthcare.
The mandate sets the aspiration for London to achieve up to 18,646 new budget holders by March 2021.

Extend existing collaborative working to new community and industry partners.
Building on the national programme “Fire as a health asset”, London is about to set up a Leadership Coalition to access as yet untapped skills, knowledge and resources to support the mobilisation of community partners. The London Fire Service and the The Co-operative are likely to be confirmed as ‘founding partners’. They are located in your geographies and are keen to collaborate. The Healthy London Partnership are happy to broker introductions.

Digital enabled self-care is the future and evidence shows that people want it.
NHS England and other partners recognise the contribution that digital can make to achieving the £584m efficiency aspiration. Yet progress in this area is sometimes thwarted by concerns that some sections of the population do not want, have or are able to access digital support. This is despite evidence showing that most people do. Further evidence shows that providing socially excluded people with digital literacy skills increases the opportunity to engage and transact with the NHS and access NHS approved health information. The Widening Digital Participation programme found a 46% reduction in participants who would have attended GP or A&E for non-urgent medical advice after attending a digital literacy course.

Work collaboratively with London SPGs to maximise the value of national programmes.
By agreeing to work collaboratively at a London level to share learning, good practice and data, all London SPGs can benefit from their involvement in new national initiatives supporting Patient Activation, Digital Literacy and Personal Health Budgets for Maternity.

SPG and CCG Leaders can benefit from the support on offer from the Healthy London Partnership.
The Personalisation and Self-Care programme, in partnership with other HLP programmes, will support SPGs and CCGs by:

To June 2016
• Improving SPG & CCG understanding of the characteristics of effective social prescribing, patient activation, peer support/education/coaching based on London’s good practice in partnership with HLP primary care and prevention programmes.
• Modelling CCG LTC population data to demonstrate how Self-Care can impact on activity and demand management to achieve ROI.
• Reaching a pan-London agreement on new contractual arrangements to support the major expansion of Personal Health Budgets and embedding person-centred care and support planning.
• Brokering new partnership relationships with the London Fire Service and other industry and community partners to enhance local collaborative working.

Post July 2016
• Publishing Self-Care “How to guides” and running “How to seminars” providing support on the optimal conditions, operational changes, size and scale required to achieve best-case ROI for the above Self-Care approaches.
• Developing model service specifications for commissioning Self-Care interventions to enable scale and spread
• Understanding local population demand for digital self-service provided through online Citizen Accounts and Personal Health Budget applications in partnership with the London Digital Programme to influence investment decisions.
• Developing standards for Personal Health Budget applications to help achieve efficiencies that will be created through automated back office functions and by providing people with the opportunities to manage their own budget through online applications.
Policy context, demand for Self-Care and key themes
## Setting the Context

### Financial Imperative and Focus on Cost Containment and Sustainability

<table>
<thead>
<tr>
<th><strong>Policy and Strategy</strong></th>
<th><strong>National Information Board</strong></th>
<th><strong>National Self-Care Programme</strong></th>
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<tbody>
<tr>
<td>FYFV - Chapter 2</td>
<td>Paper free by 2020</td>
<td>Realising the Value</td>
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<tr>
<td>Empowering Patients</td>
<td>Meaningful use of digital</td>
<td>£584m (£91.6m London)</td>
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<tr>
<td>Engaging Communities</td>
<td>opportunities</td>
<td>System change needed</td>
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<td>New models of care</td>
<td>Local Digital Roadmaps</td>
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<td>Funding, value and</td>
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<td>efficiency gap</td>
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### Planning and Delivery

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<th>Planning Guidance</th>
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<tr>
<td>Increase patient</td>
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<tr>
<td>activation and self-care</td>
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<tr>
<td>Increased take up of</td>
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<td>Personal Health and</td>
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<td>Integrated Budgets</td>
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<td>50-100,000 new budget</td>
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<td>holders (&gt;18,646 for</td>
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<td>London) by March 2021</td>
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<tr>
<td>New Care Models must</td>
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<tr>
<td>reflect self-care</td>
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<td>Local Digital Roadmaps</td>
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### STP Planning, Implementation and Support

<table>
<thead>
<tr>
<th>HLP Personalisation</th>
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<tr>
<td>Programme</td>
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<td>Evolving Case for Change</td>
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<td>Operationalising Self-Care</td>
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<tr>
<td>Activating People</td>
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<td>Activating Communities</td>
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| Sustainability and       |
| Transformation Plans     |
| Evidence of patient      |
| activation, self-care    |
| and uptake of PHBs       |
| Local Digital Roadmaps   |
| aligned to Self-Care    |

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<th>HLP Interdependencies</th>
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<td>Digital</td>
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<td>Prevention</td>
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<td>Primary Care</td>
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<td>Workforce</td>
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<td>Mental Health</td>
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<td>U&amp;EC</td>
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### 2016 – Focus on Delivery - Translating concepts into reality
Realising the potential of Self-Care & Personalisation

Realising the Value programme
• Developing the evidence base.
• Working closely with 5 community partners to test ways to embed approaches.
• Creating tools to allow these to have national and local impact.
• Outputs not available until September 2016.

<table>
<thead>
<tr>
<th>Programme</th>
<th>15/16</th>
<th>16/17</th>
<th>17/18</th>
<th>18/19</th>
<th>19/20</th>
<th>20/21</th>
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<tbody>
<tr>
<td>Right Care</td>
<td>-</td>
<td>113</td>
<td>487</td>
<td>879</td>
<td>1,273</td>
<td>1,542</td>
</tr>
<tr>
<td>Low Value Interventions</td>
<td>-</td>
<td>14</td>
<td>76</td>
<td>127</td>
<td>174</td>
<td>205</td>
</tr>
<tr>
<td>New Care Models</td>
<td>(68)</td>
<td>(69)</td>
<td>38</td>
<td>189</td>
<td>538</td>
<td>908</td>
</tr>
<tr>
<td>UEC</td>
<td>(66)</td>
<td>108</td>
<td>316</td>
<td>535</td>
<td>643</td>
<td>895</td>
</tr>
<tr>
<td>Self Care</td>
<td>-</td>
<td>6</td>
<td>91</td>
<td>190</td>
<td>373</td>
<td>584</td>
</tr>
<tr>
<td>Prevention (PHE Accountability)</td>
<td>-</td>
<td>13</td>
<td>57</td>
<td>102</td>
<td>148</td>
<td>179</td>
</tr>
<tr>
<td>Total</td>
<td>(134)</td>
<td>185</td>
<td>1,064</td>
<td>2,022</td>
<td>3,149</td>
<td>4,313</td>
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Empowered Citizens
Empowered Communities
Can London realise the £91.6m efficiency savings aspiration?
Evidence of demand shows that people want Self-Care and they have been waiting over 10 years to receive it

The Conjoint Research (2015) conducted by YouGov for NHS England presents compelling evidence that people want self-care and to access health services in a variety of ways including digitally.

- Customers emphatically confirmed the importance of 4 key areas; multi channel offer by intent; consistent and timely response tailored to contact scenario; personalisation through an NHS account; making it easy to self serve. These top 4 attributes were consistent across all population groups
- Younger people and people frequently contacting the NHS have increasing preference for web-based solutions instead of traditional solutions like face to face and phone.

Survey size 3,762 (Conjoint Research, 2015)

The MORI research conducted in 2005 also highlights public demand for self-care

- More than 9 in 10 respondents were interested in being more active, and around half said they were ‘very interested’ in playing a more active part in self-care
- 82% of people with an LTC said they already play an active role in their care but would like to play a more active part.
- More than 75% of people with an LTC said that if they had guidance and support from a professional or peer they would feel far more confident about taking care of their own health.

(DH, 2005)
Evidence base is strong and consistent enough to support effective action but many approaches to choose from and some overlapping

- **Patient Education & Health Literacy**
- **Collaborative consultations & shared decision making**
- **Personalised care planning and delivery**
- **Peer Support**
- **Personal Budgets**
- **Asset-based community development**
- **Partnerships with community partners**
- **Social Prescribing**
- **Community volunteering for health**
- **Volunteers as part of NHS family**
- **Co-production with local communities**
- **Patient Activation**
- **Digital Engagement**
- **Workforce Development**
Focus on the ‘Aces’: More coherence when approaches grouped into three themes when determining high value

A ♠
Self-Management Support

A ♠
Community-based Approaches

A ♠
Enabling Approaches

Value Generation
The 3 themes can help SPGs to consider what to focus on

**Self Management Support**
- Self Management Education/ Health Literacy
- Collaborative Decision Making
- Personalised Care Planning and Delivery
- Peer Support
- Personal Health Budgets
- Health Coaching

**Community-Based Approaches**
- Group Activities for Health and Wellbeing
- Asset-based approaches in health and wellbeing context

**Enabling Approaches**
- Patient Activation
- Workforce Development
- Digital Engagement

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**Realising the Value**
- Peer support
- Self-Management Education
- Health Coaching
- Group Activities to support health and Wellbeing
- Asset based approaches

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**HLP, Dec 2016**

**National Consortium, Jan 2016**

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Na&onal Consor&um,
Jan 2016

HLP,
Dec 2016
Summary of impact and value: Self-Management Support
# Self-Management Education & Health Literacy

## What is Self Management Education?

**Health literacy** is about ‘the capacity to obtain, process and understand basic health information and services needed to make appropriate health decisions (Institute of Medicine).

**Self-management education** complements traditional patient education (which tends to be information and skills focused) in ‘supporting patients to live the best possible quality of life with their chronic condition’ (Bodenheim).

## Condition areas

<table>
<thead>
<tr>
<th>Condition areas</th>
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<tbody>
<tr>
<td>Adults with chronic conditions</td>
</tr>
<tr>
<td>Strongest evidence in</td>
</tr>
<tr>
<td>• Diabetes</td>
</tr>
<tr>
<td>• Arthritis</td>
</tr>
<tr>
<td>• Chronic pain</td>
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## Examples

- Range of evaluated programmes, some disease-specific (e.g., Arthritis Self-Management Programme), and some are applied across a range of conditions (e.g. Chronic Disease Self-Management Course, subsequently adapted for the Expert Patient Programme)

Programmes include a range of elements including the following which are common to many:

- Patient education on a range of topics (mainly conditions-specific) e.g. self-monitoring, symptom management, healthier behaviours
- Psychological support and skills e.g. CBT approaches, dealing with depression, stress management, problem-solving
- Support for living well with chronic conditions e.g. peer support, communication skills, goal-setting, motivational interviews

## Evidence of Impact and Value

### Individual health & wellbeing

| Improved knowledge and self-efficacy |
| Improved metabolic control (diabetes) and disease control (range of conditions) |
| Improved psychological health status - stress, coping, and quality of life |

### Contribution to Efficiency and Sustainability

| Increased self-care, symptom management, and health behaviours |
| Potential to alleviate the pressure on health and social services |
| Example: ‘self-empowerment and education’ could reduce hospital admissions by 25-30% (LHC) |

### Wider social outcomes

| Potential to support other patients through peer education and support |
| Improved capacity to be involved in local community |

## Key Sources

Collaborative consultations & shared decisions

**What are collaborative consultations and shared decision-making?**

**Collaborative consultations** involve ‘purposeful, structured conversations that combine clinical expertise with patient-driven goals of wellbeing and which connect to interventions (Nesta 2013)**

**Shared decision-making** ‘a process in which patients can review all the treatment options available to them and participate actively with their healthcare professional in making that decision.....and take a treatment route which best suits their needs and preferences ‘ (NHS England 2015).

**Condition areas**

Adults with long-term conditions

Strongest evidence in:

- diabetes
- coronary heart disease
- depression

**Examples**

Collaborative consultation and/or shared decision-making are more often described in the evidence as aspects of broader approaches or programmes than as stand-alone interventions. Common aspects of these approaches include:

- Patient-practitioner conversations which take account of patients’ needs, preferences and goals as well as clinical information
- Provision of relevant information about long-term conditions, treatment options, healthy behaviours etc.
- Opportunities to ask questions, explore options, access peer support
- Jointly agreeing treatment goals and reviewing progress and options over time

**Evidence of Impact and Value**

**Improved health & wellbeing**

- Increased knowledge about healthy behaviours, choices of treatment etc. and improved confidence to self-manage
- Improved physical and psychological health status and self-reported quality of life
- Improved relationships with healthcare providers

**Contribution to Efficiencies and Sustainability**

- More effective and efficient use of primary care, and greater satisfaction with care
- Agreed treatment priorities and increased compliance with medication  self-monitoring
- Example: ‘Redefining consultations and providing access to peer support could reduce the cost of healthcare by 7% (Nesta)

**Wider social outcomes**

- Improved relationships between patients and health-care providers.
- Potential to support other patients through peer education and support

**Key Sources**

Nesta (2013) *The business case for people powered health* England: Nesta / Innovation Unit

Coulter et al (2015) *Personalised care planning for adults with chronic or long-term health conditions* Cochran Review

**Personalised Care Planning & Delivery**

<table>
<thead>
<tr>
<th>What is Personalised Care Planning and Delivery?</th>
<th>Condition areas</th>
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| **Personalised Care Planning** is ‘an anticipatory (forward-looking), negotiated discussion or series of discussions between a patient and a health professional (perhaps with other professional or family members present) to clarify goals, options and preferences and develop an agreed plan of action based on this mutual understanding’ (Coulter et al, 2015). | Adults with long-term conditions  
Strongest evidence in:  
• Physical disability  
• Mental Illness |

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| **Personalised care delivery** takes a range of forms – ranging from one-off provision of equipment, information and advice or support, to tailored care plans including a range of interventions (e.g. the ‘Your Way’ approach to personalisation for people living with mental illness). It includes:  
- Personalised care planning involving patients, health-care staff, carers or family members  
- Agreed approaches to care delivery and monitoring, based on patients’ priorities and preferences and clinical advice  
- Often includes elements of self-management education and/or peer support |

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<th>Evidence of Impact and Value</th>
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<tbody>
<tr>
<td><strong>Improved health &amp; wellbeing</strong></td>
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<tr>
<td>Improvement in health-related behaviours and/or self-care activity in 9 of 10 studies measuring this (Cochran Review – Coulter)</td>
</tr>
<tr>
<td>Some improvements in health status (e.g. blood glucose, depression, blood pressure)</td>
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<tr>
<td>E.g. Significant improvements in wellbeing for people with mental illness (MHF)</td>
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<tr>
<td>E.g. reductions in costs compared to traditional care (MHF – Your Way)</td>
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<table>
<thead>
<tr>
<th>Key Sources</th>
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</table>
| Coulter et al (2015) *Personalised care planning for adults with chronic or long-term health conditions* Cochran Review  
Mental Health Foundation (2015) *Your Way: an evaluation of a model of community mental health support developed by Together for Mental Wellbeing* (online)  
## Peer Support

<table>
<thead>
<tr>
<th>What is Peer Support?</th>
<th>Condition areas</th>
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| Peer Support is ‘a system of mutual aid based on principles of respect, shared responsibility and empathic understanding of the other’s situation. This understanding stems from a common experience, based on the belief that someone who has faced and overcome adversity can offer support, encouragement, hope and guidance to others who face similar situations’ (Campos 2012) | Strongest evidence:  
• mental illness  
• dementia  
• ‘stigmatising conditions’ |

### Examples

Core elements involve recruitment, training, support and supervision of people with relevant lived experience to support others living with similar health issues, ethnic or cultural experience, and/or social exclusion challenges. Support may be provided individually and/or in groups, in person or by phone or online, and in a range of venues. Examples of evaluated peer support approaches include:
- Peer support with people receiving in-patient and community NHS mental health services in Nottingham (Health Foundation 2014)
- Peer support and involvement of volunteers to support dementia patients and carers in south London (Semple et al 2015)
- Homeless Health Peer Advocacy provided by Groundswell in London (Finlayson / Young Foundation 2016)

### Evidence of Impact and Value

<table>
<thead>
<tr>
<th>Improved health &amp; wellbeing</th>
<th>Contribution to Efficiencies &amp; Sustainability</th>
<th>Wider social outcomes</th>
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| Improved wellbeing, quality of life, self-esteem, coping strategies | Improved understanding and use of health services and some quantified reductions in health service usage  
E.g. 14% reduction in hospital stays (mental health)  
E.g. 68% reduction in missed NHS appointments and 42% reduction in unplanned activity (homeless health) | Wider benefits reported for carers, volunteers and staff.  
Improvement in peer supporters’ wellbeing, confidence and recovery  
E.g. SROI of £1.71 to £5.18 for every £1 invested in dementia peer support  
Increased networking and integration into community |

### Key Sources

Nesta / Health Foundation (2015) *Peer support: what is it and does it work?*  
+ reports of individual studies in Case for Change
## Personal Budgets

### What are Personal Budgets?

A personal health budget is an amount of money to support a person’s identified health and wellbeing needs, planned and agreed between the person and their local NHS team. The vision for personal health budgets is to enable people with long term conditions and disabilities to have greater choice, flexibility and control over the health care and support they receive. (DH, 2012:2)

### Condition areas

- Continuing Healthcare needs
- Physical, sensory, LD
- LTCs, Mental Health
- New areas like maternity

### Examples

Personal health budgets may be given as:

- a direct payment = cash payments given to patients in lieu of directly provided services they have been assessed as needing; or
- a notional budget, where the money is retained but spent on the individual’s behalf and on agreed provision; or
- a budget held by a third party to which the individual patient delegated responsibility for commissioning and purchasing; or
- a combination of these arrangements (Alakeson 2014 and Gadsby 2013).

Example: Mike is a quadriplegic requiring 24 hour nursing care who was offered a place in a nursing home but wanted to maintain his independence and stay at home with his wife. The CCG offered him a PHB which he decided would be managed by a third party. The initial package of care (in 2012) cost £505,386 with an agreed reduction of approx. 1/3 being achieved over the following three years. (See HLP’s Case for Change for full details and Alakeson for further case study examples)

### Evidence of Impact and Value

<table>
<thead>
<tr>
<th>Improved health &amp; wellbeing</th>
<th>Contribution to Efficiencies and Sustainability</th>
<th>Wider social outcomes</th>
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<tbody>
<tr>
<td>‘Significant improvements’ in care-related quality of life and psychological wellbeing</td>
<td>Improved quality and continuity of care Significantly lower inpatient care costs for PHB than control group (Forder, 2012). Note: ‘the possibility that PHBs will not release funds or deliver cashable savings’ (Gadsby)</td>
<td>Improved relationships with family and informal care-givers Ability to remain at home and integrated with community Significant positive impact on carers’ self-reported quality of life</td>
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<tr>
<td>Improved patient satisfaction, choice and control, and independence</td>
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<td>Psychological benefits including increased confidence, optimism, and motivation</td>
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### Key Sources

Summary of impact and value: Community-Based Approaches
## Community Engagement and Mobilisation

### What are Community-centred Approaches?

Community-based approaches to health and wellbeing seek to:
- recognise and mobilise community assets including the skills, knowledge and time of individuals and organisations;
- promote health in community rather than service settings, using non-clinical methods;
- promote health equity by working in partnership with individuals and groups facing barriers to good health;
- increase people’s control and facilitate the active involvement of members of the public (PHE/NHS England 2015)

### Conditions

- All

### Examples

Examples are as diverse as the communities involved, but some core elements and models of particular relevance to self-care are:
- Community volunteering for health, such as Health Champions
- Volunteers ‘as part of the extended NHS family’ such as community First Responder schemes and local Time Banks
- Peer support, education and mentoring
- Partnerships with charities, voluntary sector organisations and peers for research, co-production, and commissioning
- Asset Based Community Development (ABCD) approaches to increase local choice of health-related opportunities and services.

E.g. 94% of patients involved in activities led by **Health Champions** - reported improved knowledge about health, increased confidence, improved wellbeing. Fewer primary care consultations were required & staff morale improved (Altogether Better, 2015).

### Evidence of Impact and Value

<table>
<thead>
<tr>
<th>Improved health &amp; wellbeing</th>
<th>Contribution to Efficiencies &amp; Sustainability</th>
<th>Wider social outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Volunteering is ‘strongly associated’ with better health, lower mortality, life satisfaction &amp; decrease in depression (PHE)</td>
<td>‘An open, engaging and iterative process that harnesses the energies of clinicians, patients, carers, citizens and local community partners’ is a key requirement for STPs (NHS England 2015)</td>
<td>Improved social networks and inclusion</td>
</tr>
<tr>
<td>Increased confidence to manage own health and care, better experience of care, and improved health outcomes (RtV 2016)</td>
<td>Increased choice of health-promoting services, with more efficient use of NHS provision and fewer emergency admissions or A&amp;E visits (RtV)</td>
<td>Decreased stigma associated with mental health and other conditions</td>
</tr>
</tbody>
</table>

### Key Sources

- Realising the Value (2016) *At the heart of health: realising the value of people and communities* England: Nesta / Health Foundation
**Social Prescribing**

**What is Social Prescribing?**

Social prescribing is a way of linking primary care patients with sources of appropriate, non-medical support in the community (Kinsella, 2015). Social prescribing can be an effective way to signpost and improve public awareness of the range of services offered locally to people with chronic conditions or those most at risk of developing health problems.

<table>
<thead>
<tr>
<th>Condition areas</th>
</tr>
</thead>
<tbody>
<tr>
<td>Long term conditions</td>
</tr>
<tr>
<td>Mental Health</td>
</tr>
<tr>
<td>Prevention of primary conditions</td>
</tr>
</tbody>
</table>

**Example**

Rotherham’s social prescribing pilot, was independently evaluated by Sheffield Hallam University and the findings are summarised below. The approach engaged 1,607 individuals (1.5% of the population) and was supported by a Project Manager and five Voluntary and Community Sector Advisors (VCSAs). It was delivered in partnership with local voluntary and community organisations, between them offering a menu of 31 social prescribing options to patients. The researchers estimate potential cost savings based on follow-up of 559 patients, using HES data, and demonstrated a range of outcomes using validated measures (e.g. for wellbeing). Reduced A&E attendance (12% to 20%, with greater reduction for longer-term follow-up group). If the pilot were replicated in London, an estimated investment of £147m for social prescribing targeting people with long-term conditions could produce a NHS saving of £207m, of which the evidence suggests could lead to a £60m net cost reduction (see LHP’s Case for Change for full details).

**Evidence of Impact and Value**

<table>
<thead>
<tr>
<th>Improved health &amp; wellbeing</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Positive change in at least one outcome area (e.g. feeling positive, managing LTC symptoms)</td>
<td>Cost savings between £1.41 and £3.38 over 18 to 24 months per £1 invested.</td>
<td>Stimulates increased choice – and makes more efficient use of existing health-related services</td>
</tr>
<tr>
<td>Improved subjective wellbeing for 83% of those followed-up on wellbeing measures</td>
<td>Reduced A&amp;E attendance (from 12 to 20%, with greater reductions for longer-term follow up).</td>
<td>Improved partnerships between NHS and local voluntary and community sector</td>
</tr>
<tr>
<td>Increased confidence, and greater sense of control over health and wellbeing.</td>
<td>Reduced outpatient appointments (15% to 21%).</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Reduced hospital admissions (14% to 21%).</td>
<td></td>
</tr>
</tbody>
</table>

**Key Source**

Summary of impact and value: Enabling Approaches
## Patient Activation

### What is Patient Activation?

Patient Activation refers to patients’ willingness and ability to take independent actions to manage their health and care and relates to an individual’s knowledge, confidence, beliefs, skills and ability to take on roles to self-manage their own health and healthcare (Hibbard and Greene, 2013).

### How Patient Activation relates to Self-care

Evidence suggests that investing in supporting patients to become more activated will be critical to the scaling-up of self-care. There is also some evidence Patient Activation approaches need to take account of patient demographics to ensure they contribute to tackling health inequalities – for example Alexander et al found higher levels of activation among employed patients and among Caucasian patients, and Hibbard et al found higher activation levels among people of higher socioeconomic status.

People with low activation levels are more likely to:

- feel overwhelmed with the task of managing their health;
- have little confidence in their ability to have a positive impact on their health;
- misunderstand their role in the care process;
- have limited problem-solving skills;
- have had substantial experience of failing to manage their health;
- have become passive in managing their health; and
- say that they would rather not think about their health (Hibbard and colleagues, 2008, 2013 and 2014).

### Evidence of Impact and Value

<table>
<thead>
<tr>
<th>Improved health &amp; wellbeing</th>
<th>Contribution to Sustainability</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Increased engagement in healthy behaviours such as exercise and healthy eating.</td>
<td>More effective communication with health care providers.</td>
<td>Potential to support other patients through peer education and support</td>
</tr>
<tr>
<td>Less health-damaging behaviour such as smoking or drug-use.</td>
<td>The evidence linking activation levels with hospitalisation, A&amp;E attendance, and adherence to medication requires further scrutiny.</td>
<td>Potential to be more actively involved in family and community activities related to health and wellbeing</td>
</tr>
<tr>
<td>Improved uptake of preventative interventions e.g. screening and check-ups</td>
<td>Studies of outcomes in specific LTCs (i.e. diabetes and asthma) show promising results.</td>
<td></td>
</tr>
</tbody>
</table>

### Key Sources

- Hibbard, J and Gilburt, H (2014) *Supporting people to manage their health* An introduction to patient activation
Workforce development

What is Workforce Development in relation to self-care?

The commitment, knowledge, skills, and confidence of healthcare staff is highlighted in much of the evidence as a critical pre-condition for successful action to promote self-care. Specific education and training approaches mentioned include: enhanced communication skills, training in health coaching, motivational interviewing, psychologically informed approaches to LTC management, support for developing more collaborative approaches, and learning from patients and peer workers. Researchers and UK policy-makers also highlight the need for cultural change within health services to increase the emphasis on partnership with patients, carers, families and communities and to shift from medically-led approaches to those which also value the expertise, skills and assets others bring to the management of long-term conditions.

How Workforce Development links to self-care

Key points from the evidence emphasise the importance of:
• supporting ‘the cultural change that is needed to create a more personalised NHS’ (Darzi, reported by RCN)
• recognising shared decision-making will not succeed if either clinician or patient are reluctant to participate (Coulter/ Cochran)
• relationships between physician & patient as a ‘leverage point’ for changing patient behaviours, attitudes & activation (Alexander et al)
• participatory relationships as ‘one of the most successful factors promoting healthy behaviours’ in LTCS (Bodenheimer)

Evidence of Impact and Value

<table>
<thead>
<tr>
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<th>Wider social outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enhanced engagement with self-care approaches – in turn delivering benefits described in previous sections</td>
<td>Increased levels of patient activation and engagement in self-care – in turn delivering benefits described in previous sections</td>
<td>More effective communication between patients and providers</td>
</tr>
<tr>
<td>Increased engagement in healthy behaviours and management of LTCS</td>
<td></td>
<td>Improved staff engagement, learning, and morale</td>
</tr>
</tbody>
</table>

Key Sources

Alexander et al (2012)Patient-Physician role relationships & patient activation among individuals with chronic illness HealthServRes:47
Coulter A et al (2015) Personalised care planning for adults with chronic or long-term health conditions Cochran
**Digital Engagement**

### What is Digital Engagement?

The use of digital products to transform the way the public engage with care and support to improve their health and wellbeing.

### How Digital Engagement relates to Self-care

Evidence suggests digital engagement and activation have much to offer in supporting both patients and staff to take effective action related to patient activation, choice and engagement in self-care. The National Improvement Board’s 2014 report on data and technology states ‘Our ambition is for a health and care system that enables people to make healthier choices, to be more resilient, to deal more effectively with illness and disability when it arises, and to have happier, longer lives in old age: a health and care system where technology can help tackle inequalities and improve access to services’. Patient and public views emphasise the role technology can play in supporting them to be more actively involved, yet the majority have access to ‘digitally-enabled transactions with the NHS’ (NIB).

### Evidence of Impact and Value

<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>Web-based interventions improved health behaviour outcomes - exercise, nutrition, knowledge of treatment, participation in care, slower decline (Wantland et al)</td>
<td>Web-based interventions can be an alternative to face-to-face, alleviating pressure on the NHS</td>
<td>Web-based advice and interventions can be widely disseminated to large parts of the population, reaching people who don’t access GPs.</td>
</tr>
<tr>
<td>Computerised CBT recognised by NICE (2006) as an option for anxiety &amp; depression, and can increase access</td>
<td>There is ‘extensive evidence’ for the productivity potential of data &amp; technology Eg. tele-access pilots in Airedale reduced hospital admissions for care home residents by 45% (NIB)</td>
<td></td>
</tr>
<tr>
<td>Having ‘multiple and clearly available contact channels’ is key to patient experience (Carn &amp; Clark – YouGov)</td>
<td>73% of physicians surveyed believe health technology will improve quality of care longer-term (California Healthcare Foundation)</td>
<td></td>
</tr>
</tbody>
</table>

### Key Sources

- Sarasohn-Khan J (2011 and 2012) *The Online Couch* and *The Connected Patient* California Healthcare Foundation
Rollout of Patients Online in London

What is Patients Online?

Patients Online is an NHS England programme which supports patients to book and cancel GP appointments online, order repeat prescriptions online and to provide access to their GP medical record online.

Potential non cash releasing efficiency savings achieved through increased roll out of Patients Online in London

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Online - GP Bookings - 1. Online Booking Saving</td>
<td>£1.8</td>
<td>£9.1</td>
<td>£11.8</td>
<td>£12.1</td>
<td>£12.4</td>
</tr>
<tr>
<td>Patient Online - GP Bookings - 2. Cancelled Online Booking Saving</td>
<td>£0.3</td>
<td>£1.2</td>
<td>£1.6</td>
<td>£1.6</td>
<td>£1.7</td>
</tr>
<tr>
<td>Patient Online - Repeat prescription handled electronically</td>
<td>£1.8</td>
<td>£9.9</td>
<td>£12.8</td>
<td>£13.2</td>
<td>£13.6</td>
</tr>
<tr>
<td>Patient Online - Cost Saving From Online DNA advantage</td>
<td>£1.1</td>
<td>£1.7</td>
<td>£0</td>
<td>£0</td>
<td>£0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>£5.0</strong></td>
<td><strong>£22.0</strong></td>
<td><strong>£26.2</strong></td>
<td><strong>£26.9</strong></td>
<td><strong>£27.7</strong></td>
</tr>
</tbody>
</table>

Evidence of Impact and Value

<table>
<thead>
<tr>
<th>Potential Patient Benefits</th>
<th>Potential GP savings</th>
</tr>
</thead>
<tbody>
<tr>
<td>• £0.29 per patient per online appointment booked / cancelled or amended.</td>
<td></td>
</tr>
<tr>
<td>• £3.67 per patient per repeat prescription ordered .</td>
<td></td>
</tr>
<tr>
<td>• £3.67 per patient per electronic message sent and received with no face to face required.</td>
<td></td>
</tr>
<tr>
<td>Emessaging</td>
<td>£11.46 GP practice savings in phone calls, car journeys and time per avoided consultation. Data is currently not available to report on the number of avoided consultations.</td>
</tr>
</tbody>
</table>

Key Sources

Personalisation and Participation Programme (2015) Case for Change
## What is the Digital Literacy?

Digital literacy aims to address the challenges of reducing health inequalities by increasing digital inclusion. Being digitally included enables individuals to seek out information online to help them better manage their own health and wellbeing. Digital literacy steers people to seeking alternatives to traditional face to face services.

## How Digital Literacy relates to Self-care

There is an overlap between digitally excluded populations and the people most at risk of poor health.

### Summary of Key Facts

<table>
<thead>
<tr>
<th>Description</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>23% of adults in the UK lack basic online skills</td>
<td></td>
</tr>
<tr>
<td>Digital inequalities broadly follow the lines of social disadvantage</td>
<td></td>
</tr>
<tr>
<td>42% of people aged 16-65 are unable to understand or make use of everyday health information (61% when numeracy skills are required)</td>
<td></td>
</tr>
<tr>
<td>20-40% of the population have low levels of activation</td>
<td></td>
</tr>
<tr>
<td>NHS England action on digital inclusion 2016-2020</td>
<td></td>
</tr>
</tbody>
</table>

### Evidence of Impact and Value from the Widening Digital Participation Programme

<table>
<thead>
<tr>
<th>Improved health &amp; wellbeing</th>
<th>Contribution to Efficiencies and Sustainability</th>
<th>Wider social outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Improved knowledge about healthy living.</td>
<td>• 48% of learners saved time by doing health related activities online</td>
<td>• Improved partnership working</td>
</tr>
<tr>
<td>• Increased flexibility in bookings bring benefits in time and convenience.</td>
<td>• Potential to reduce demand on face to face health service demands.</td>
<td>• Digital skills are transferrable and can be used in other areas of participants lives.</td>
</tr>
<tr>
<td>• Participants may feel more included in society</td>
<td>• Nearly half of the 34% of learners that would have gone straight to their GP or A+E for non-urgent medical advice would seek advice from websites first.</td>
<td></td>
</tr>
<tr>
<td>• Increased choice</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Key Sources


Summary of Key Reading


Nesta (2013) The business case for people powered health England: Nesta / Innovation Unit


NHS England (2015b) Customer contact programme, research and analysis: Understanding customer priorities through conjoint testing England: PA Knowledge Limited


Realising the Value (2016) At the heart of health: realising the value of people and communities England: Nesta and The Health Foundation

Next steps

- **April 2016**: HLP Personalisation and Participation programme recruits Complex Change Manager and Senior Researcher to help with STP development and implementation.

- **April 2016**: Personalisation & Self-Care interdependencies with HLP Primary Care, Digital, Prevention and Workforce programmes confirmed. Plan and Programme Leads agreed.

- **June 2016**: SPGs confirm Self-Care interventions and PHB population segments in STP plans.

- **July 2016 onwards**: Publication of “How to guides”, support seminars held as part of package of support to SPG and CCG leads.
### Personalisation Programme Governance and Team

#### Delivery Group (Board)
Programme governing body accountable to the Transformation Board

**Senior Responsible Officers**
Graham MacKenzie – Joint SRO (London CCGs)

**London Strategic Planning Group Leads**
Angela Bhan – South East London
Jessica Brittin – North East London
Trish Longdon – North West London
Lucie Waters – South West London
Rob Meaker – North East London
Maria O’Dwyer – North Central London

**Local Authority**
Bernie Flaherty – London ADASS

**CCG Chief Finance Officer**
Robert Whitefield – Enfield CCG

#### Design Group
Assure requirements and priorities of local communities are reflected in all design principles

**Clinical Leads**
Debbie Frost - North Central London
Victoria Tzortziou - North East London
Peter Ilves - South West London
Lis Paice - North West London

**Patient Public Representatives**
Varsha Dodhia - North West London
Michael Morton - North West London
Andrew Carpenter – North West London
Lana Samuels – South West London

**Local Authority**
Tristan Brice - London ADASS
Jonathan Hildebrand - ADPH London

**Acute Provider**
Michael Bell – Croydon Health

**Voluntary/Community Sector**
Mike Wilson - Healthwatch
Eithne Rynne - LVSC
Zoe Portlock – Bromley-by-Bow

**HLP Programmes**
Mike Part – London Digital
TBC – Primary Care
TBC – Prevention
TBC - Workforce

#### Programme Team
Shaun Crowe – Programme Lead
Selina Frater – Programme Manager
Helen Davies – Independent Consultant
Raj Karsandas – Clinical Lead
Alex Edwards Financial Modeller